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Promotion and protection of all human rights, civil, political, economic, social and cultural rights, including the right to development

Contributions of the right to health framework to the effective implementation and achievement of the health-related Sustainable Development Goals

Report of the United Nations High Commissioner for Human Rights

Summary

In the present report, submitted pursuant to Human Rights Council resolution 35/23, the United Nations High Commissioner for Human Rights discusses the contributions of the right to health framework to the effective implementation and achievement of the health-related Sustainable Development Goals. He recalls the human rights underpinnings of the 2030 Agenda for Sustainable Development, and the close linkages between the right to health and the health-related Goals. In the report, he highlights the fact that the international standards on the right to health provide normative guidance in addressing several challenges relating to the implementation of the health-related Goals, such as aligning law and policy with human rights, operationalizing the pledge to leave no one behind, accountability and participation. The report also contains several examples of emerging good practices in applying the right to health framework.

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I. Introduction

1. The present report has been prepared pursuant to Human Rights Council resolution 35/23, in which the Council requested the United Nations High Commissioner for Human Rights to prepare a report that presents contributions of the right to health framework to the effective implementation and achievement of the health-related Sustainable Development Goals, identifying best practices, challenges and obstacles thereto, and to submit it to the Council at its thirty-eighth session.

2. In preparing the report, the Office of the United Nations High Commissioner for Human Rights (OHCHR) consulted and took into account the views of a range of stakeholders, as the Council encouraged it to do. A total of 49 contributions were received from Member States, United Nations bodies, human rights treaty bodies, special procedure mandate holders, national human rights institutions, academia and civil society organizations. All submissions are available on the OHCHR website.[1]

II. The right to health in international human rights law

3. The right of everyone to the enjoyment of the highest attainable standard of physical and mental health is a fundamental right that is indivisible from, and interdependent and interrelated with, all other human rights. It is recognized in human rights instruments adopted at both the global and the regional levels, including in article 25 (1) of the Universal Declaration of Human Rights and article 12 of the International Covenant on Economic, Social and Cultural Rights. The right to health is also enshrined in the International Convention on the Elimination of All Forms of Racial Discrimination, the Convention on the Elimination of all Forms of Discrimination against Women, the Convention on the Rights of the Child, the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families and the Convention on the Rights of Persons with Disabilities.[2]

4. This section highlights key aspects of the normative right to health framework that has been prepared by international human rights mechanisms. The general comments of the Committee on Economic, Social and Cultural Rights and other treaty bodies provide authoritative guidance on the normative content of the right and on the scope of State obligations, including priority interventions towards the progressive realization of the right.

5. In paragraph 11 of its general comment No. 14 (2000) on the right to the highest attainable standard of health, the Committee on Economic, Social and Cultural Rights interprets the right to health as an inclusive right, encompassing both the underlying determinants of health and access to timely and appropriate health care. The right to health contains both freedoms, such as the right to control one's health and body and the right to be free from interference, and entitlements, such as the right to a system of health protection that provides equality of opportunity for people to enjoy the highest attainable level of health.[3] Regarding sexual and reproductive health in particular, freedoms include the right to make free and responsible decisions and choices, free of violence, coercion and discrimination, about matters concerning one's body and sexual and reproductive health and rights. Entitlements, on the other hand, include unhindered access to a range of health facilities, goods, services and information, which ensure all persons full enjoyment of the right to sexual and reproductive health.[4]

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[1] See www.ohchr.org/EN/Issues/ESCR/Pages/HealthFramework.aspx.

[2] Regional instruments recognizing the right to health include: the African Charter on Human and Peoples' Rights; the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights; and the European Social Charter.

[3] See Committee on Economic, Social and Cultural Rights, general comment No. 14 (2000) on the right to the highest attainable standard of health, para. 8.

[4] See Committee on Economic, Social and Cultural Rights, general comment No. 22 (2016) on the right to sexual and reproductive health, para. 5.

6. The following interrelated and essential elements are part of the normative content of the right to health:[5]

(a) Availability, which requires functioning public health and health-care facilities, goods and services to be available in sufficient quantity within the State;

(b) Accessibility, which requires health facilities, goods and services to be affordable and physically accessible to all on the basis of non-discrimination;

(c) Acceptability, which requires health facilities, goods and services to be gender-sensitive, culturally, scientifically and medically appropriate and respectful of medical ethics;

(d) Quality, which requires health facilities, goods and services to be scientifically and medically appropriate.

7. The right to informed consent is a fundamental dimension of the right to physical and mental health. It protects the right of the patient to be involved voluntarily and sufficiently in medical decision-making, and assigns associated duties and obligations to health-care providers. Important components of informed consent include: (a) respect for legal capacity, generally determined by the ability to comprehend, retain, believe and evaluate information provided in arriving at a decision; (b) respect for personal autonomy, without coercion, undue influence or misrepresentation; and (c) completeness of information, including associated benefits, risks and alternatives to a medical procedure.[6]

8. The human rights-based approach arising from these norms also requires that health authorities and other duty bearers be held accountable for meeting human rights obligations in public health, including through the possibility for rights holders to seek effective remedies when their right to health is violated, through effective judicial complaints mechanisms or other appropriate avenues for redress. States have an obligation to ensure the meaningful participation of all stakeholders in the development, implementation and monitoring of health policy.

9. The International Covenant on Economic, Social and Cultural Rights provides for the progressive realization of the right to health and other economic, social and cultural rights. At the same time, it also imposes on States parties various obligations that have immediate effect, such as guaranteeing the exercise of the right without discrimination, and taking deliberate, concrete and targeted measures to move as expeditiously and effectively as possible towards the full realization of the right, using the maximum available resources. States parties have core obligations to ensure the satisfaction, at the very least, of a minimum essential level of the right, including: (a) ensuring access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups; (b) ensuring access to basic shelter, housing and sanitation, and an adequate supply of safe and potable water; (c) providing essential drugs, as defined in the World Health Organization (WHO) Model List of Essential Medicines; (d) ensuring the equitable distribution of all health facilities, goods and services; and (e) adopting and implementing a national public health strategy and plan of action.[7] Additional obligations of comparable priority include ensuring reproductive, maternal and child health care, and providing immunization against the major infectious diseases occurring in the community, education and access to health information and training for health personnel, including education on health and human rights.[8]

[5] See Committee on Economic, Social and Cultural Rights, general comment No. 14, para. 12.

[6] See A/64/272, sects. II–III.

[7] See Committee on Economic, Social and Cultural Rights, general comment No. 14, para. 43.

[8] Ibid., para. 44.

III. The 2030 Agenda for Sustainable Development and the right to health

A. Human rights underpinnings of the Sustainable Development Goals

10. The 2030 Agenda for Sustainable Development is grounded in the Universal Declaration of Human Rights, international human rights treaties and other instruments.[9] As a result, the Sustainable Development Goals seek to realize the human rights of all and to achieve gender equality and the empowerment of all women and girls.[10] In addition to reaffirming the importance of the Universal Declaration of Human Rights and other international instruments relating to human rights and international law, States also underscore their responsibility, in conformity with the Charter of the United Nations, to respect, protect and promote human rights and fundamental freedoms for all, without distinction of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, disability or other status.[11] The pledges to leave no one behind and to endeavour to reach the furthest behind first evoke the key human rights principles of equality, non-discrimination and inclusion.[12]

11. While the Sustainable Development Goals themselves are not framed explicitly in the language of human rights, virtually all of the Goals explicitly reflect the contents of corresponding key economic, social and cultural rights. Many of the targets under the Goals address availability, accessibility, including economic accessibility (affordability), and quality of education, health, water and other services related to those rights, with targets on access to safe, nutritious and sufficient food for all, universal health coverage, free, equitable and quality primary and secondary education, access to safe and affordable water, sanitation, hygiene and housing and access to safe, effective, quality and affordable essential medicines and vaccines for all.[13]

12. The 2030 Agenda reaffirms human rights for all, without distinction of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, disability or other status.[14] It also pays particular attention to women and girls, and to those in situations of vulnerability, such as children, youth, persons with disabilities, persons living with HIV/AIDS, older persons, indigenous peoples, refugees and internally displaced persons and migrants.[15]

B. Health in the Sustainable Development Goals

13. As stated by the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, health is central to the Sustainable Development Goals, as it is both an outcome of and a path to achieving poverty reduction and sustainable development. Progress in health is both dependent on and a consequence of progress towards other Goals.[16] The supremely ambitious and transformational vision envisaged by the 2030 Agenda is of a world with equitable and universal access to quality education at all levels, to health care and social protection, where physical, mental and social well-being are assured.[17]

14. While the right to health is intrinsically connected to several Goals and targets, Goal 3, on ensuring healthy lives and promoting well-being for all at all ages, is the principal

[9] See General Assembly resolution 70/1, para. 10.
[10] Ibid., third preambular paragraph.
[11] Ibid., para. 19.
[12] Ibid., para. 4.
[13] See A/HRC/34/25, paras. 8 and 10.
[14] See General Assembly resolution 70/1, para. 19.
[15] Ibid., para. 23.
[16] See A/71/304, para. 6.
[17] See General Assembly resolution 70/1, para. 7.

health-related Goal, and its targets cover a broad range of health concerns. These targets address: (a) maternal mortality (target 3.1); (b) preventable deaths of newborns and children under 5 years of age (target 3.2); (c) AIDS, tuberculosis, malaria and neglected tropical diseases, hepatitis, waterborne diseases and other communicable diseases (target 3.3); (d) premature mortality from non-communicable diseases, mental health and well-being (target 3.4); (e) the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol (target 3.5); (f) road traffic accidents (target 3.6); (g) universal access to sexual and reproductive health-care services, and the integration of reproductive health into national strategies and programmes (target 3.7); (h) universal health coverage, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all (target 3.8); and (i) deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination (target 3.9).

15. Goal 3 targets also aim to: strengthen the implementation of the WHO Framework Convention on Tobacco Control in all countries (target 3.a); support the research and development of vaccines and medicines for the communicable and non-communicable diseases that primarily affect developing countries and provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health (target 3.b); substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States (target 3.c); and strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks (target 3.d).

16. Many of the targets deal with elements that resonate and are consistent with human rights norms and standards. For example, target 3.3 recalls the prevention, treatment and control of epidemic, endemic, occupational and other diseases envisaged in article 12 (2) (c) of the International Covenant on Economic, Social and Cultural Rights, with control including the making available of relevant technologies, the use and improvement of epidemiological surveillance and data collection on a disaggregated basis and the implementation or enhancement of immunization programmes and other strategies of infectious disease control.[18] Under article 12 (2) (d) of the Covenant, universal health coverage, considered in greater detail below, entails the creation of conditions that would assure to all medical service and medical attention in the event of sickness. Access to medicines, covered in target 3.b, evokes one of the core obligations under the right to health. The human rights framework, particularly on the right to health, can positively contribute to the realization of the 2030 Agenda. The following section will consider how the right to health framework can contribute to the achievement of the Sustainable Development Goals.

IV. Applying the right to health framework in implementing the health-related Sustainable Development Goals

A. Normative guidance

17. One of the key cross-cutting commitments of the 2030 Agenda is that its implementation should be in accordance with the rights and obligations of States under international law,[19] including human rights norms and standards. States therefore have an imperative to integrate the key human rights principles and international norms and standards arising from the right to health into the framing and implementation of laws, policies and practices, in order to achieve the health-related Sustainable Development Goals.

18. The High-Level Working Group on the Health and Human Rights of Women, Children and Adolescents, co-convened in May 2016 by OHCHR and WHO to secure

[18] See Committee on Economic, Social and Cultural Rights, general comment No. 14, para. 16.

[19] See General Assembly resolution 70/1, para. 18.

political support for the implementation of the human rights-related measures required by the Global Strategy for Women's, Children's and Adolescents' Health (2016–2030), indicated that a human rights-based approach was essential for the following reasons: (a) it supports States in meeting their obligations under international human rights law; (b) it offers a principled basis for universal access to health services, emphasizing that interventions must be non-discriminatory, transparent and participatory, and founded on strong public accountability; (c) it requires focus on both the empowerment of rights holders and the responsibilities of duty bearers; (d) it aims to enhance the capacity of duty bearers at the local, district and national levels to meet their obligations to respect, protect and fulfil human rights in transparent, effective and accountable ways; (e) it requires full and informed participation by all those affected by any action or policy; and (f) it builds true sustainability into health systems and towards improving health outcomes by requiring that the underlying determinants of health be tackled, including through the realization of health-enabling rights.[20]

19. The Special Rapporteur on extreme poverty and human rights observed that human rights provided a context and a detailed and balanced framework that: invoked the specific legal obligations that States had agreed upon in the various human rights treaties; emphasized that certain values were non-negotiable; brought a degree of normative certainty; and brought into the discussion the carefully negotiated elaborations of the meaning of specific rights that had emerged from decades of reflection, discussion and adjudication.[21] Crucially, in view of the people-centred underpinnings of the 2030 Agenda, the language of rights recognizes the dignity and agency of all individuals (regardless of race, gender, social status, age, disability or any other distinguishing factor) and it is intentionally empowering.[22] This is particularly true for the right to health.

B. Addressing key challenges

20. The following section contains a consideration of a selection of key challenges connected with the effective implementation and achievement of the health-related Sustainable Development Goals, and the contribution of the right to health framework in addressing them.

1. Realizing health and health-related rights

21. The realization of the right to health is dependent on the exercise, without discrimination, of other human rights, be they civil, political, economic, social or cultural. When the right to health is protected, the enhanced enjoyment of other rights necessary to preserve dignity, realize potential and assert autonomy becomes possible.[23] However, while the right to health framework is well established, health policymakers often miss the opportunity to integrate human rights principles, norms and standards into policy development, implementation and monitoring, as well as into mechanisms for accountability, which would improve process and policy outcomes for rights holders. The Special Rapporteur on health refers, in this regard, to an implementation gap, noting that while the fundamental principles and the main processes and mechanisms of the right to health are well identified, there still remains a significant gap between the formulation of health policies and their effective implementation in everyday practice. This is so even where the formulation of health policy is satisfactory from a human rights standpoint.[24] A number of factors account for this implementation gap, and some of the most significant include: a growing trend that favours a narrow and selective approach to human rights that

[20] More information in this regard is available from www.ohchr.org/EN/Issues/Women/WRGS/Pages/MaternalAndChildHealth.aspx.

[21] See A/70/274, para. 65.

[22] Ibid.

[23] World Health Organization (WHO), *Leading the realization of human rights to health and through health: Report of the High-Level Working Group on the Health and Human Rights of Women, Children and Adolescents* (2017), p. 10.

[24] See A/HRC/29/33, para. 40.

ignores or insufficiently addresses one or more rights, including the right to health, of a group of the population; a failure to address human rights as determinants of health; and a tendency towards policy fragmentation across areas that affect health.[25] Applying the principle of the interdependence and indivisibility of all human rights is therefore essential for the full realization of the right to health.[26]

22. Strong and committed leadership, including at the highest levels, is indispensable if effect is to be given to the changes necessary to integrate human rights into public health on a sustainable basis. Such leadership is crucial for rectifying the "pathologies of power": the power imbalances that are often at the root of poor health outcomes for persons in disadvantaged and vulnerable situations.[27] These power differentials cut across relations between government and governed, communities and established authorities, health personnel and the persons they serve, and those who determine social, cultural, religious and other norms and practices and those who are, effectively, compelled to abide by them even to their detriment. Without committed leadership and effective participation, negative power dynamics are likely to continue to undermine the enjoyment of the right to health.[28] Dedicated leadership would oversee the implementation of a coordinated approach to health policy in a whole-of-government push to engage other sectors whose policy has an impact on health, examples being the education, trade, water and sanitation, nutrition and transport sectors.[29] This coordinated approach would have, as a key goal, the realization of "the whole nexus of intersecting, interdependent rights".[30]

2. Aligning law and policy with human rights

23. A legal and policy framework anchored in human rights norms is crucial to ensuring the effective implementation of the Sustainable Development Goals relating to the full realization of human rights, including the right to health. In the last decade, there have been significant setbacks regarding the realization of the right to health and human rights in general. The Special Rapporteur on health expressed concern that the effects of the tendency to adopt a selective approach to human rights are most detrimental for groups that are already experiencing discrimination and that are often unable to access health services, with the result that poverty, social exclusion, inequalities and discrimination are reinforced and health suffers.[31] Other negative trends impacting the right to health include rising inequalities, which have seen indigenous peoples, minorities, persons with disabilities and other populations and groups in vulnerable situations face barriers to access to essential services.

24. In the area of sexual and reproductive health and rights, restrictive laws and policies in some countries threaten the gains that have been made so far, particularly in preventable maternal and child mortality. The use of penal laws to hinder access to maternal health services, and to criminalize entire population groups, such as lesbian, gay, bisexual, transgender and intersex persons, sex workers and persons who use drugs, contributes to stigma and discrimination. Its correlation with poor health outcomes of those groups is well documented.

25. In tandem with the protection of the right to health in national law and the adoption of a national health policy, the right to health framework requires that States adopt legislative, administrative, budgetary, judicial, promotional and other measures towards the

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[25] Ibid., para. 42.

[26] Ibid., para. 43.

[27] Paul Farmer, *Pathologies of Power: Health, Human Rights, and the New War on the Poor* (University of California Press, 2004).

[28] Alicia Ely Yamin and Rebecca Cantor, "Between insurrectional discourse and operational guidance: challenges and dilemmas in implementing human rights-based approaches to health", Journal of Human Rights Practice, vol. 6, No. 3 (November 2014), p. 463.

[29] WHO, *Leading the realization of human rights to health and through health: Report of the High-Level Working Group on the Health and Human Rights of Women, Children and Adolescents* (2017), p. 35.

[30] Ibid., p. 11.

[31] See A/HRC/29/33, paras. 42 and 44–45.

full realization of the right to health.[32] Interventions towards these objectives include a comprehensive assessment of the extent to which existing legal and policy frameworks comply with the human rights norms applicable to health and well-being, through a participatory, inclusive and transparent process, with stakeholder consultation throughout. Such an assessment could be followed by measures to: (a) repeal, rescind or amend laws and policies to align them with human rights norms; (b) enact laws and implement policies promoting positive measures to ensure that essential health services, including primary health-care, sexual and reproductive health services, maternal health services, and neonatal, child and adolescent health services, are available, accessible, acceptable and of good quality;[33] and (c) ensure accountability, as more fully set out below.

3. Operationalizing the pledge to leave no one behind

26. The central promise of the 2030 Agenda to leave no one behind and to reach the furthest behind first effectively mirrors the human rights principle of equality and non-discrimination. In the section below, the High Commissioner explores the challenges in operationalizing this commitment, viewed from the perspective of women's rights, as well as in the two specific areas of neglected health concerns and universal health coverage. The pledge to leave no one behind should be reflected in all policy areas, including accountability and participation.

(a) Women and girls

27. The 2030 Agenda aspires to a world in which every woman and girl enjoys full gender equality and all legal, social and economic barriers to their empowerment have been removed. Achieving gender equality will contribute significantly to the achievement of the Sustainable Development Goals as a whole. Goal 5 explicitly calls on all States to empower all women and girls and achieve gender equality by 2030. Equality between men and women is protected by several human rights instruments and is a cornerstone of human rights law.[34] Nevertheless, the denial of the health and health-related rights of women and girls remains widespread, as a result of discrimination, exclusion and traditional, cultural, social and other norms and practices that place women and girls in positions of inferiority or subordination in the home, the community, the workplace and broader society. Cumulative and intergenerational impacts of gender-based discrimination and inequality have grave consequences for the health outcomes of half of the world's population.[35]

28. Other obstacles to the realization of the right to health of women and girls include legal, procedural, practical and social barriers to access to the full range of sexual and reproductive health facilities, services, goods and information.[36] Harmful gender stereotypes and practices, such as child and forced marriage, female genital mutilation, the preferential care of boys and violence against women also contribute to poor health outcomes.[37] Unequal access to quality education and employment limits the opportunities available to girls and women to ensure their agency. The lack of financial independence and, in particular, of agency, frequently means that women and girls are unable to access good quality health services that also meet the criteria regarding acceptability, especially gender sensitivity: a vital element concerning their ability to exercise their sexual, reproductive and other health rights.

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[32] See Committee on Economic, Social and Cultural Rights, general comment No. 14, paras. 33 and 36.

[33] Jyoti Sanghera and others, "Human rights in the new Global Strategy", British Medical Journal, vol. 351, supplement 1 (September 2015), pp. 42–43.

[34] See International Covenant on Civil and Political Rights, art. 3; International Covenant on Economic, Social and Cultural Rights, art. 3; and Convention on the Elimination of All Forms of Discrimination against Women, arts. 1–2.

[35] In its report entitled *Leading the Realization of Human Rights to Health and through Health*, the High-Level Working Group on the Health and Human Rights of Women, Children and Adolescents notes that "preventable death, ill-health and impairment are firmly rooted in the failure to protect human rights" (p. 7).

[36] See Committee on Economic, Social and Cultural Rights, general comment No. 22, para. 2.

[37] See www.ohchr.org/Documents/Publications/FactSheet23en.pdf.

29. As well as requiring that States take all appropriate measures to eliminate discrimination against women in the field of health care, in order to ensure, on the basis of equality of men and women, access to health-care services, the right to health framework calls for attention to be paid to the underlying determinants of women's health.[38] Interventions to prevent and treat diseases and conditions affecting women, and to respond to gender-based violence should be part of a national strategy to promote health throughout the course of life. The health needs and rights of women belonging to vulnerable and marginalized groups, such as migrant women, refugee and internally displaced women, older women, indigenous women and women with disabilities, should receive special attention.[39] As recommended by the Committee on the Elimination of Discrimination against Women, States should: (a) monitor the provision of health services to women by public, non-governmental and private organizations, to ensure equal access and quality of care; (b) require all health services to be consistent with the human rights of women, including the rights to autonomy, privacy, confidentiality, informed consent and choice; and (c) ensure comprehensive, mandatory, gender-sensitive training on women's health and human rights for health workers.[40]

(b) Addressing neglected health concerns: mental health

30. The right to health encompasses both physical and mental health, without placing preferential value on either one. Yet, despite mental health conditions affecting one in four persons over their lives, persons affected by mental health conditions experience social and other forms of exclusion on a broad scale, and mental health remains marginalized in many ways.[41] The stigma and discrimination to which many persons with mental health conditions are subjected, in the community, in other social environments and contexts and in health-care settings, discourage them from seeking the health care and services they need. A frequently isolating experience, living with mental health conditions is commonly typified by the denial of many other rights, such as the rights to work, to education, to an adequate standard of living and to housing. Forced treatment and other harmful practices within mental health institutions, such as solitary confinement, forced sterilization, the use of restraints, forced medication and overmedication, not only violate the right to free and informed consent provided for by the Convention on the Rights of Persons with Disabilities, but constitute ill-treatment that may amount to torture.[42] Marginalization of mental health is a significant challenge: there are data and research gaps, especially with regard to the human rights situation of persons with mental health conditions, and financial and human resource allocations for mental health are all symptomatic of the lesser value routinely ascribed to mental health.[43]

31. As the above outline endeavours to demonstrate, the marginalization of certain health concerns inevitably brings about the marginalization of affected persons. A core obligation under the right to health is the duty to adopt and implement a national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population.[44] A participatory and transparent process, incorporating periodic reviews, should be employed in the development of the strategy and plan, and special attention accorded to all vulnerable or marginalized groups. The neglect of these issues in health and other relevant policy, and of the persons affected by them, signals certain serious shortcomings in ensuring the availability, accessibility, acceptability and quality of health services, facilities and goods, and in upholding accountability and the right

[38] See Convention on the Elimination of All Forms of Discrimination against Women, art. 12 (1); Committee on the Elimination of Discrimination against Women, general recommendation No. 24 (1999) on women and health, para. 6.

[39] See Committee on the Elimination of Discrimination against Women, general recommendation No. 24, paras. 6 and 29.

[40] Ibid., para. 31 (d), (e) and (f).

[41] See www.who.int/mental_health/maternal-child/child_adolescent/en/; and submission of International Disability and Development Consortium, pp. 2–3.

[42] See A/HRC/34/32, para. 33.

[43] Ibid., paras. 19 and 21.

[44] See Committee on Economic, Social and Cultural Rights, general comment No. 14, para. 43 (f).

to participation. Reaching first those who are furthest behind and leaving no one behind calls for their equal prioritization along with other health concerns relevant to the population as a whole.

(c) Universal health coverage

32. The 2030 Agenda endorses a commitment to achieve universal health coverage for all, which remains an important challenge. According to the International Labour Organization (ILO), 46.3 per cent of the global population and 56 per cent of the global rural population lack health coverage. Approximately 48 per cent of the population, and more than half of older persons worldwide, have no access to long-term care as a result of insufficient numbers of the skilled workers needed for service delivery.[45] Largely ignored in health policy, long-term care is widely perceived as free care, to be provided by unpaid female family members. However, such unpaid care does have economic implications, such as loss of income opportunities and the resulting risk of impoverishment.[46]

33. There is a broad diversity of views regarding what universal health coverage entails, and the traditional role played by the private sector in voluntary insurance schemes has been very influential in the conception of health coverage in general. Although target 3.8 of the Sustainable Development Goals refers to financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all, universal health coverage is not defined in the 2030 Agenda, nor is there any mention of the need to prioritize marginalized and vulnerable populations and groups, such as those living in poverty.[47]

34. In the absence of a clear definition of universal health coverage in the Sustainable Development Goals, the international human rights framework and the right to health framework can provide guidance and standards to improve health outcomes for all people, without discrimination. The Special Rapporteur on health cautions that not all paths to universal health coverage are consistent with human rights standards, noting in particular the risk of entrenching inequalities where, for instance, Governments prioritize the expansion of coverage to privileged groups in the formal sector.[48] A human rights-based approach to universal health coverage, recommended by the High-Level Working Group on Health and Human Rights,[49] fundamentally requires that availability, accessibility, acceptability and quality be ensured, and that persons in vulnerable situations who are mostly excluded from universal health coverage be prioritized. A human rights-based approach to universal health coverage calls, among other requirements, for the creation of conditions that would ensure to every person all appropriate medical service and medical attention in the event of need,[50] universal coverage of quality primary health services for children[51] and the elimination of discrimination in health care and services, especially in relation to the core obligations of the right to health.[52] Thus, universal health coverage refers not merely to an expansion of coverage for health services but also to access, for every person throughout the course of life, to the full complement of necessary and appropriate health care and services on the basis of non-discrimination.[53]

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[45] International Labour Organization (ILO), *World Social Protection Report 2017–19: Universal social protection to achieve the Sustainable Development Goals* (2017), pp. 104–109.

[46] Ibid., p. 108.

[47] See A/71/304, para. 76.

[48] Ibid.

[49] WHO, *Leading the realization of human rights to health and through health: Report of the High-Level Working Group on the Health and Human Rights of Women, Children and Adolescents* (2017), p. 34, recommendation 2.

[50] See International Covenant on Economic, Social and Cultural Rights, art. 12 (2) (d).

[51] See Committee on the Rights of the Child, general comment No. 15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health, para. 73 (b).

[52] See Committee on Economic, Social and Cultural Rights, general comment No. 14, para. 19.

[53] WHO, *Leading the realization of human rights to health and through health: Report of the High-Level Working Group on the Health and Human Rights of Women, Children and Adolescents* (2017), p. 15.

35. The human rights framework helps to further clarify the responsibilities of States regarding universal health coverage to: (a) ensure the participation of stakeholders in the design of policies to implement universal health coverage;[54] (b) refrain from inappropriate health resource allocation that would disproportionately favour expensive curative health services, which are often accessible only to a small, privileged fraction of the population, over primary and preventive health care benefiting a far larger part of the population; (c) adopt legislative and other measures ensuring equal access to health care and health-related services provided by third parties;[55] (d) ensure that availability, accessibility, acceptability and quality of health facilities, goods and services are not undermined by health sector privatization;[56] and (e) uphold and implement the right to social security, including the implementation of social protection floors, as part of measures to ensure financial risk protection.[57]

4. Accountability for health

36. In the 2030 Agenda, the General Assembly foresees a robust, voluntary, effective, participatory, transparent and integrated follow-up and review framework to support national implementation and to maximize and track progress to ensure that no one is left behind. It aims to promote accountability, support effective international cooperation and foster the exchange of best practices and mutual learning.[58] A global indicator framework, including for the health-related Goals, has since been developed by the Inter-Agency and Expert Group on Sustainable Development Goal Indicators, endorsed by the Statistical Commission and adopted by the General Assembly.[59] It is to be complemented by indicators at the regional and national levels. OHCHR has underscored the need for a robust accountability mechanism at the global level under the high-level political forum on sustainable development, and for the forum's voluntary national reviews and thematic reviews to draw systematically on information and recommendations from the United Nations human rights mechanisms. Moreover, as recognized in the 2030 Agenda, accountability in the private sector should be ensured based on the Guiding Principles on Business and Human Rights.[60]

37. Accountability is a complex, multidimensional concept. Human rights-based accountability requires numerous forms of review and oversight and fostering of the accountability of multiple actors at various levels, both within and beyond the health sector.[61] Accountability comprises at least three fundamental components: monitoring, independent review and remedial action.[62] Effective monitoring is critical, not as an end in itself, but as a tool for measuring progress and improving accountability. Each of these components is indispensable and has a discrete role to play in strengthening accountability.[63]

38. Challenges around ensuring accountability for health include the failure to differentiate between these components, with the result that one or more may be neglected,

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[54] Submission by Health Poverty Action, p. 4.

[55] See Committee on Economic, Social and Cultural Rights, general comment No. 14, para. 35.

[56] Ibid.

[57] See International Covenant on Economic, Social and Cultural Rights, art. 9; ILO Social Security (Minimum Standards) Convention, 1952 (No. 102); ILO Social Protection Floors Recommendation, 2012 (No. 202); ILO Medical Care Recommendation, 1944 (No. 69); and ILO Medical Care and Sickness Benefits Convention, 1969 (No. 130).

[58] See General Assembly resolution 70/1, paras. 72–73.

[59] General Assembly resolution 71/313.

[60] See General Assembly resolution 70/1, para. 67.

[61] See A/HRC/21/22, paras. 74–75.

[62] Commission on Information and Accountability for Women's and Children's Health, "Keeping promises, measuring results", p. 7; Independent Accountability Panel, *2016: Old Challenges, New Hopes, Accountability for the Global Strategy for Women's and Children's and Adolescents' Health*, pp. 9–11; and A/HRC/21/22.

[63] Carmel Williams and Paul Hunt, "Neglecting human rights: accountability, data and Sustainable Development Goal 3", International Journal of Human Rights, vol. 21, No. 8 (2017), pp. 1118 and 1120.

as tends to happen with review in the context of development and global health, or conflated with accountability.[64] Effective monitoring, review and, ultimately, accountability, are dependent on high quality data, disaggregated, for instance, by age, sex, geographic location, ethnicity, socioeconomic status and other factors, as nationally applicable. Assessing whether the targets under the Sustainable Development Goals have been met will be equally dependent on the quality and availability of such data, two areas where major gaps, particularly at the country level, have been identified. With regard to identifying key populations vulnerable to HIV, for instance, stigma remains an obstacle to comprehensive data collection, with these populations being inadequately accounted for.[65]

39. The use of indicators is a key element of human rights-based monitoring, and the indicator framework for the Sustainable Development Goals has been assessed as "capturing only a partial measure of the impact that Goal 3 may have on people's right to health entitlements and duty bearers' corresponding obligations" and not reflecting the full extent to which health-related rights are upheld.[66] Consequently, right to health indicators are necessary to facilitate the thorough-going monitoring that would yield the information necessary for competent review and remedial action. Recourse to human rights norms also places a duty on States to cooperate towards capacity-building for data collection.

40. The High-Level Working Group on the Health and Human Rights of Women, Children and Adolescents recommended that all States should ensure that national accountability mechanisms (for example, courts, parliamentary oversight, patients' rights bodies, national human rights institutions and health sector reviews) are appropriately mandated and resourced to uphold human rights to health and through health.[67] At the national level, accountability can be enhanced through the establishment or strengthening of transparent, inclusive and participatory processes and mechanisms, with jurisdiction to recommend remedial action. Such mechanisms and processes include courts or quasi-judicial and non-judicial bodies, complaints mechanisms within the health system, patients' rights associations, national human rights institutions and professional standards associations.[68] Accountability is further strengthened by international human rights mechanisms, such as the human rights treaty bodies, the special procedures of the Human Rights Council and the universal periodic review, and regional mechanisms.

5. Participation

41. According to the General Assembly, the 2030 Agenda is a plan of action for people, planet and prosperity, which all countries and stakeholders, acting in collaborative partnership, will implement. Target 16.7 of the Sustainable Development Goals is to ensure responsive, inclusive, participatory and representative decision-making at all levels. The participation of rights holders and other stakeholders in the development, implementation and monitoring of policy is not only an imperative of the democratic process but also a prerequisite for effective policymaking, as it facilitates public health responses that are relevant to the context and ensures that interventions reach the most affected communities.[69] Promoting health must involve effective community action in setting

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[64] Ibid.

[65] Sara L.M. Davis, "The uncounted: politics of data and visibility in global health", International Journal of Human Rights, vol. 21, No. 8 (2017), p. 1149.

[66] Carmel Williams and Paul Hunt, "Neglecting human rights: accountability, data and Sustainable Development Goal 3", International Journal of Human Rights, vol. 21, No. 8 (2017), p. 1129.

[67] WHO, *Leading the realization of human rights to health and through health: Report of the High-Level Working Group on the Health and Human Rights of Women, Children and Adolescents* (2017), p. 48, recommendation 7.

[68] Jyoti Sanghera and others, "Human rights in the new Global Strategy", British Medical Journal, vol. 351, supplement 1 (September 2015), p. 44; and Committee on Economic, Social and Cultural Rights, general comment No. 14 (2000) on the right to the highest attainable standard of health, paras. 59–62.

[69] See, for example, Joint United Nations Programme on HIV/AIDS (UNAIDS), "Non-discrimination on responses to HIV" (2010), paras. 18–22; Committee on Economic, Social and Cultural Rights, general comment No. 14 (2000) on the right to the highest attainable standard of health, para. 54; European Union Agency for Fundamental Rights, *Challenges facing civil society organisations working on human rights in the EU* (Luxembourg, 2017), p. 39.

priorities, making decisions, planning, implementing and evaluating strategies to achieve better health.[70]

42. Civil society organizations play a vital role in holding authorities to account, reaching populations and communities that are frequently overlooked, and advocating for their rights. Recent trends towards restrictions on civic space, particularly limitations on the activities of civil society organizations, constitute a significant challenge to ensuring the effective participation of a wide range of stakeholders. Examples of restrictions include legislative and bureaucratic barriers, including onerous registration requirements, the harassment, intimidation and killing of advocates, censorship and the use of criminal legislation to penalize health workers, currently widespread in certain conflict situations.[71]

43. The Special Rapporteur on health refers to an unbalanced approach to human rights, where undue restrictions in the enjoyment of civil and political rights undermine the full realization of the right to health, leading to a failure to implement the principles of participation and empowerment, and undermining the crucial role that civil society can play in promoting societal health and well-being.[72] In the context of promoting human rights within the European Union for example, civil society organizations have noted that limitations include: a lack of clarity and transparency regarding who is consulted before decisions are made; no systematic consultation of all key players; limited access to information on policy or legal initiatives; and a lack of awareness of the various modes and methods of involving stakeholders in law and policymaking in a meaningful and effective way.[73]

44. In order to ensure meaningful participation, the full spectrum of stakeholders must be recognized, and those who are typically excluded from participatory processes, such as persons with disabilities, children, youth and adolescents, women, older persons and persons living in remote or rural areas, must be included. Examples of human rights-based interventions include: (a) ensuring an enabling regulatory, administrative and financial environment for civil society organizations; (b) building, through education and awareness-raising, the capacity of rights holders to participate and to claim their rights; (c) ensuring that transparent and accessible mechanisms for engaging stakeholders' participation and facilitating regular communication between rights holders and health-service providers are established and/or strengthened at the community, subnational and national levels; and (d) ensuring stakeholders' participation in priority setting, in policy and programme design, implementation, monitoring and evaluation and in accountability mechanisms.

V. Emerging good practices

45. The call for contributions towards the present report elicited a large number of submissions, including examples of what could be considered as emerging good practices. Due to space constraints, several emblematic examples are highlighted below, and all the submissions may be viewed on the OHCHR website.

46. The criteria proposed for the characterization of good health practices by the Special Rapporteur on health in 2003 are helpful in understanding whether a good health practice also amounts to a right to health good practice. From the perspective of the right to health, a good practice must: demonstrably enhance an individual's or group's enjoyment of one or more elements of the right to health; pay particular attention to groups in vulnerable situations; and be consistent with the enjoyment of all human rights in process and outcome.[74] Practices that meet the above-mentioned criteria also enhance the availability, accessibility, acceptability and quality of health facilities, goods and services, the active and

[70] See Committee on Economic, Social and Cultural Rights, general comment No. 14, para. 54.

[71] World Alliance for Citizen Participation (CIVICUS), "People power under attack: findings from the CIVICUS Monitor" (April 2017).

[72] See A/HRC/29/33, para. 58.

[73] European Union Agency for Fundamental Rights, *Challenges facing civil society organisations working on human rights in the EU* (Luxembourg, 2017), pp. 39–40.

[74] See A/58/427, para. 45.

informed participation of individuals and groups in health policies, programmes and projects and the right to health monitoring and accountability mechanisms that are effective, transparent and accessible.[75]

Enhancing the enjoyment of the right to health

47. The United Nations Population Fund (UNFPA) provided an example of expanding access to care for the poorest and most marginalized women and girls living with obstetric fistula. In 2009, Comprehensive Community Based Rehabilitation in Tanzania came together with UNFPA and Vodacom, a mobile telecommunications technology company, to work on a project to help women and girls gain access fistula repair surgery through the M-Pesa mobile telephone money transfer service. The free fistula surgery provided by Comprehensive Community Based Rehabilitation in Tanzania is now accessible to many women and girls for whom the high costs of transport were previously prohibitive. Using mobile-to-mobile banking technology, funds can now be transferred to fistula patients to cover this cost, with the help of community-based outreach workers, or "ambassadors", who identify and assist woman and girls living with fistula in their local communities. UNFPA reports that, since the project was launched, the number of women receiving fistula treatment has grown exponentially.[76]

Focus on groups in vulnerable situations

48. Morocco has integrated human rights and ethics into training on HIV and syphilis testing in prisons provided to doctors, dentists and psychologists.[77] In Mexico, following a qualitative study on stigma and discrimination in health centres, building on health personnel testimonies, training material for health personnel was developed to address stigma and discrimination.[78]

Availability of health facilities, goods and services

49. With regard to enhancing the availability of medicines, following the addition of new medicines (for the treatment of hepatitis C, tuberculosis and cancers) to the WHO Model List of Essential Medicines, in 2017, Malaysia issued a government-use licence for direct acting antivirals to allow the import of generic versions of Sofosbuvir, a hepatitis C drug.[79]

Accessibility

50. In Morocco, the Minister of Health has established a package of services dedicated to women and child victims of violence, to which all Moroccan nationals and all migrants, regardless of their migratory status, have access. In 2017, South Africa launched a national HIV plan, which is aimed at significantly reducing infection rates, discrimination and stigma by providing information, psychosocial support and treatment to all members of the lesbian, gay, bisexual, transgender and intersex community.[80] In 2017, Denmark removed self-identification as transgender from its list of mental health conditions, an important contribution to addressing the stigmatization and pathologization of diverse gender identities.[81] In Portugal, decriminalization of drug use has been helpful in decreasing stigmatization, and ensuring access to health services for all, without discrimination.[82]

51. Accessibility also means economic accessibility of health facilities, goods and services. In Australia, the National Immunisation Programme is a joint initiative of the Commonwealth Government and state and territory governments. Providing free vaccines

[75] Ibid., para. 53.
[76] Submission by UNFPA, pp. 4–5.
[77] Submission by Morocco, p. 10.
[78] Submission by Mexico, p. 4.
[79] Submission by the Major Group for Children and Youth, p. 2.
[80] Submission by the International Lesbian, Gay, Bisexual, Trans and Intersex Association, p. 10.
[81] Ibid., p. 3.
[82] Submission by Students for Sensible Drug Policy, p. 1.

through primary health-care providers, the Programme facilitates the provision of vaccines against 17 diseases, including measles, diphtheria, whooping cough, human papillomavirus and meningococcal C, which children, families and older persons can access at no cost.[83] In 2012, reforms to the health system of Mexico improved access to health coverage, making available the people's health insurance scheme, offering universal access to a comprehensive package of personal health services with financial protection.[84]

52. With regard to accessibility of health information, France has introduced the Nutri-Score nutrition-labelling scheme, which is aimed at improving nutritional information on packaging, thus guiding consumers towards choosing foods with higher nutritional value.

Cultural acceptability of health facilities, goods and services

53. In Mexico, health-care staff are trained to provide care that is culturally appropriate care for all the different sections of the population. Health-care protocols paying particular attention to indigenous women have been prepared, reclaiming traditional practices of indigenous midwives.[85] Australia has published the National Aboriginal and Torres Strait Islander Health Plan 2013–2023, which provides an overarching framework for the delivery, by the health system, of primary, secondary and tertiary health care that is evidence-based, culturally safe, of high quality, responsive and accessible for the relevant rights holders, without discrimination or racism. Additionally, the Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2016–2026 embeds cultural respect principles into the Australian health system by building the cultural competence of mainstream primary health-care services and supporting the ongoing viability of indigenous-specific health services.[86]

Monitoring and accountability for the right to health

54. In Ecuador, the Office of the Ombudsman has a constitutional mandate to protect and promote the human rights of all citizens, including by protecting the right to health. In this regard, it has taken action, both at the national and regional levels, to protect rights holders whose right to health has been violated.[87]

Community participation

55. In their joint submission, Aidsfonds and the International HIV/AIDS Alliance emphasize that community-led organizations of persons living with HIV, key populations and other affected communities have played a critical role in overcoming many of the major challenges in the HIV response, reaching persons most affected by HIV with critical HIV-prevention services, providing support for adherence to treatment and other essential health services and advocating for resources and the human rights of persons living with and affected by HIV. Examples of community responses in this area include mothers2mothers, a South African community-led initiative that has reached 1.2 million women living with HIV in nine countries. One major element of the work of mothers2mothers is the training of mothers living with HIV as mentors, supporting and advising pregnant women, and assisting them with access to services to prevent mother-to-child transmission of HIV.[88]

VI. Conclusion

56. **The 2030 Agenda for Sustainable Development is firmly anchored in human rights principles and standards. Consequently, human rights provide the normative context and international standards for the implementation of Sustainable**

[83] Submission by Australia.
[84] Submission by Mexico, p. 2.
[85] Ibid.
[86] Submission by Australia, p. 4.
[87] Submission by Office of the Ombudsman, Ecuador.
[88] Joint submission by Aidsfonds and the International HIV/AIDS Alliance, pp. 2–3.

Development Goal 3 and the other health-related Goals, with the dignity and agency of rights holders at its centre. The right to health framework can help to address some of the key challenges in implementing health-related Goals, including: enhancing the health of women, girls and adolescents; operationalizing the pledge to leave no one behind through the overarching duty to eliminate discrimination and marginalization; and securing universal health coverage. Strong leadership and determined actions to fully respect, protect and fulfil the right to health, ensure effective participation and strengthen accountability would contribute significantly to the effective implementation and achievement of the health-related Sustainable Development Goals.